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THE IGNORED FRONTIER: EXPLORING WOMEN'S RIGHTS IN ABORTION AND FEMALE GENITAL MUTILATION IN INDIA

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I. ABSTRACT

This article presents a nuanced view of the evolution of reproductive rights in India, with a specific focus on the legal landscapes surrounding abortion and the practice of female genital mutilation. It traces the historical trajectory from the contentious criminalization of miscarriage in the 1960s to the enactment of the Medical Termination of Pregnancy Act in 1971. Furthermore, it highlights the pivotal 2021 Amendment to the MTP Act of 1971 and its consequential 2022 judgment of X v. NCT of Delhi, which underscores the ongoing evolution of reproductive rights in the country. Parallelly, the article delves into the shadowy realm of FGM in India, highlighting its origins, prevalence, and the intricate web of legal and health repercussions it entails. It confronts the challenges faced by the government in tackling this unregulated practice, including the cloak of religious sanction and the dearth of official data. Moreover, the narrative advocates for heightened awareness campaigns, urgent medical interventions for FGM survivors, and stringent legal measures against its proponents. Throughout its discourse, the article underscores the importance of a compassionate and rights-based approach to reproductive rights. It calls for a comprehensive strategy that includes legal reforms, awareness campaigns, and support services for survivors.

II. KEYWORDS

Abortion, FGM, Reproductive Right, Autonomy, Women's Health

III. INTRODUCTION

Gender equality has evolved into a multifaceted concept in India. Historically, India has been a patriarchal society where gender roles and expectations have been deeply entrenched. However, over the past few years, the country has also witnessed prominent movements that have helped shape a greater gender–equal society.

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Initially, gender equality movements were mostly restricted to males or upper-caste females and were one of the stepping stones for achieving political motives[3]. It was in the late 1970s when the intersectional barrier among women was broken, catapulting the issue of gender equality into national discourse. By the advent of the third wave of feminism[4], the notion of objectification of women was being tackled, as evidenced by the passing of laws against domestic violence, sexual harassment, workplace harassment, women's position as a "*Karta*", and women's contribution to the defence sector. Since then, the government has begun to take active measures to strengthen women-centric laws in the pursuit of gender equality, spurred by the horrific crimes and practises being committed against women and campaigns such as the #MeToo movement. Despite these efforts, there still remain areas that have been less explored or left untouched by Indian law.

Abortion, a human right, was not recognised as a legal right until 1971[5], which was followed by stricter amendments that ignored woman's autonomy and were mainly intended to control female infanticide, leading to a terrible skewed sex-ratio up until 2022[6]. Preferring the bodily autonomy of a woman over her body, the Apex Court in 2022 liberalised abortion laws by extending their exercise period to up to 24 weeks for all women. Although India was among the first countries in the world to legalise abortion, its local laws remain untraceable for practises such as FGM. The practise of genital mutilation or genital cutting in females involves partial or entire removal of external genitalia, usually undertaken by the Dawoodi Bohra Community that migrated from Egypt and Yemen to India in 1500s. The consequences of FGM can be severe and can have both short-term and long-term effects on a female's physical and mental health.

[3] Western Michigan University ScholarWorks at WMU, https://scholarworks.wmich.edu/cgi/viewcontent.cgi?article=5120&context=masters_theses (last visited Feb.18, 2023).
[4] Gender Matters, https://www.coe.int/en/web/gender-matters/feminism-and-women-s-rights-movements (last visited Feb. 18, 2023).
[5] Medical Termination of Pregnancy Act, 1971 (India).
[6] Press Information Bureau, https://pib.gov.in/PressReleasePage.aspx?PRID=1782601 (last visited Feb. 18, 2023).

This paper elaborates on the act of Indian judiciary balancing between two exactly opposite stances on the respective reproductive rights – abortion and female genital mutilation – making women's rights more susceptible to being infringed. It also makes an attempt to emphasise the significance of the Indian government and court taking a stronger and more steadfast stance to guarantee the protection and respect of women's rights.

IV. CONNOTATION OF HEALTH vis-à-vis REPRODUCTIVE RIGHTS

Reproductive rights play a crucial role in the overall well-being of women, encompassing their autonomy and health. By denying women the ability to make decisions about their own bodies, we perpetuate a distressing cycle of oppression and hardship. Without the freedom to exercise reproductive rights, women are deprived of control over their reproductive health, coerced into unwanted pregnancies, and pushed into resorting to unsafe abortions in desperate situations. Limited access to reproductive healthcare not only infringes upon women's fundamental rights but also undermines their economic empowerment, curtailing educational opportunities and career prospects.

The deprivation of 'Reproductive rights' is of two forms, *first*—denial of autonomy in decisions about their reproductive health, and *second*—denial of access to necessary resources to exercise those decisions. Processes that are affected by denial of such basic forms are—Right to access contraception and family planning methods; Right to access and use safe and legal abortion services; Right to comprehensive sexual education; Right to make decisions about one's own fertility; Right to consent to marry; Right to privacy; Right against gender-based discrimination/violence; Right against female genital mutilation; and Right to medical care during pregnancy, childbirth and postpartum. As it encompasses a bundle of rights, the Reproductive Right becomes essential in realisation of civil, political, social and economic rights.

V. Recognition of Reproductive Rights

The Constitution of India has recognised Reproductive Rights as an integral part to Article 21[7], especially in terms of personal liberty and right to privacy, substantiated by the other two sides of the golden triangle—Articles 14 and 15[8]—right to equality and non-discrimination. These provisions are crucial for ensuring that everyone, regardless of their gender or caste, has equal access to reproductive health services and can make choices about their own bodies and lives. Adhering to the Directive Principles under Article 51(c)[9] to respect international law and treaties, the Indian government and judiciary have referred to international conventions such as—-the UDHR[10] ;ICESCR [11] ;CEDAW[12] ;CRC[13] ;the ICPD[14] and the SDGs[15] of 2015, which have upheld the sanctity of reproductive rights as an indispensable tool of human rights.

VI. JUDICIAL INTERPRETATION OF REPRODUCTIVE RIGHTS

In the post-independence era, the Supreme Court and State High Courts have highlighted several aspects of reproductive rights and have considered their violations to be detrimental to women's rights. This below section illustrates the significant rulings that have aided to the realisation of women's reproductive rights, specifically the autonomy of consent, the right to timely and quality maternal health, the right to free access to contraceptives, the right to make an informed choice regarding one's own fertility, the right to a safe and legal abortion, and freedom from forced childbearing.

- ***Maternal Health***

Reproductive rights comprise fundamental freedoms and choices regarding reproductive health, including childbirth, contraception, and safe abortion. Maternal health is crucial as it directly impacts women's well-being and autonomy during

[7] INDIA CONST. art. 21.
[8] INDIA CONST. art. 14 & 15.
[9] INDIA CONST. art. 51, cl.c.
[10] Universal Declaration of Human Rights, 1948.
[11] International Covenant on Economic, Social & Cultural Rights, 1976.
[12] Convention on the Elimination of All Forms of Discrimination against Women , 1979.
[13] Convention on the Rights of the Child, 1989.
[14] International Conference on Population and Development, 1994.
[15] Agenda for Sustainable Development, http://surl.li/ffcqm (last visited Feb., 20 2023).

pregnancy, childbirth, and postpartum. The Sample Registration System (SRS)[16] revealed that India's MMR is at 97/lakh live deaths, which has been perceived as *progressive decline* from the MMR ratio of 130/lakh in 2014-16, ignoring the vital cause of maternal deaths—high suicidal rates in the perinatal period. The perinatal period can be an emotionally challenging time for women due to a combination of hormonal changes, physical stressors, and psychosocial factors.

Unfortunately, the stigma associated with mental health issues and the lack of awareness and support exacerbate the vulnerability of women during this critical period. According to a study conducted by an independent health reporting organisation in 2016 it was found that 7.6% of women were exposed to the risk of suicide[17] which indicates a distressing trend wherein the burden of maternal mortality is not solely limited to physical complications but also extends to the psychological well-being of expectant and new mothers. Realising the importance of comprehensive and quality maternal health care as a key aspect of reproductive rights, the Delhi High Court in 2010, in **Laxmi Mandal v. Deen Dayal Harinagar Hospital**[18], and **Jaitun v. Maternity Home**[19], upheld that preventive maternal deaths are a fundamental rights violation. The Court highlighted the failure of government machinery in the implementation of National level schemes—National Maternity Benefit Scheme (NMBS), Integrated Child Development Scheme (ICDS) and Janani Soraksha Yojana (JSY), which were originally framed with the intent to curb the exponential growth in maternal deaths.

Along the lines of the Delhi High Court, the Madras High Court in **Sandesh Bansal v. Union of India**[20] rejected the financial constraints as a ground for violation of reproductive rights and reiterated that, ***"the inability of women to survive pregnancy and child birth violates her fundamental right to live as guaranteed under Article 21***

[16] Significant Decline in the Maternal Mortality Ratio (MMR) from 130 in 2014-16 to 97 per lakh live births in 2018-20: Dr. Mansukh Mandaviya,Press Information Bureau (Feb. 20, 2023, 9:00 A.M.), https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1879912
[17] India Is Trying To Reduce Maternal Mortality Without Addressing A Key Contributor: Suicide, Health Policy Watch (Feb. 20, 2023, 9:00 A.M.), https://healthpolicy-watch.news/india-maternal-mortality-suicide/
[18] Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors., (2010) 8853/2008.
[19] Jaitun v. Maternity Home, MCD, Jangpura & Ors., W.P. No. 10700/2009.
[20] Sandesh Bansal v. Union of India, W.P.(C) 81/2012.

of the Constitution of India" and ***"it is the primary duty of the government to ensure that every woman survives pregnancy and child birth."*** Prioritising maternal health encourages women to use their reproductive rights, which improves pregnancy outcomes, lowers the rate of maternal mortality, and improves the general well-being of women and their families.

- ***Abortion***

Abortion is the termination of a pregnancy by removing the embryo or foetus from the uterus, preventing its potential birth. It is crucial for women's health, well-being, and future decisions. It allows them to choose whether or when to become a parent, considering their personal circumstances. It also safeguards women's rights and gender equality, allowing them to participate fully in social, educational, and professional spheres without unintended pregnancies. Access to safe and legal abortion services is essential for protecting women's health and lives, preventing risks associated with unsafe procedures. The first legislation which legalised abortion was the Medical Termination of Pregnancy Act, 1971 (**"the Act of 1971"**). The law represented a positive step towards the realisation of reproductive rights, although the idea of reproductive autonomy to abort was contentious. The Supreme Court's ruling, in **Samar Ghosh v. Jaya Ghosh**[21], dismantled women's unilateral reproductive autonomy to seek abortions and ruled that doing so would amount to cruelty, made it clear that the abortion was contingent on marital permission. The Supreme Court in 2009 revisited the issue of reproductive autonomy when it considered the abortion of a "*mentally ill*" woman who had been raped by the state-run facility in **Suchita Srivastava & Anr. v. Chandigarh Administration**[22], prompting a reexamination of the concept of reproductive autonomy. The Court held, "*There is no doubt that a woman's right to make reproductive choices is also a dimension of 'personal liberty' as understood under Article 21.*"

[21] Samar Ghosh v. Jaya Ghosh, (2007) 4 SCC 511.
[22] Suchita Srivastava and Anr. v. Chandigarh Administration, (2009) 9 SCC 1. [hereinafter *Suchita Srivastava*]

In 2017, the Supreme Court upheld a woman's right to protect her own life from avoidable danger by allowing abortion at 24 weeks[23]. The practice was permitted but only under certain circumstances, such as anencephaly. This resulted from ongoing efforts since 2008 to push the legal limit on abortion to 20 weeks for medical reasons. In 2022, the Apex Court in **X v. The Principal Secretary, Health and Family Welfare Department, Govt. of NCT of Delhi**[24] while interpreting the Medical Termination of Pregnancy (Amendment) Act of 2021 ("**2021 Amendment Act**"), issued a ruling extending the term of abortion up to 24 weeks. The Court stated, "*116. **In the context of abortion, the right to dignity entails recognising the competence and authority of every woman to take reproductive decisions including the decision to terminate the pregnancy.** Although human dignity is inherent in every individual, it is susceptible to violation by external conditions and treatment imposed by the state.*" Abortion empowers women with autonomy over their bodies and reproductive choices, but denied access can lead to unsafe practices, endangering their lives and negatively impacting their emotional and physical health.

- ***Female Genital Mutilation***

Female genital mutilation, or FGM, is a practise in which a woman's genitalia are modified or removed for non-medical purposes. Usually between infancy and puberty, this is frequently done to young girls without their knowledge or consent. FGM is a deeply ingrained cultural practise that is practised in numerous cultures all over the world. According to the National Health Portal, 3 million women are at risk of FGM each year, and it is estimated that almost 200 million surviving females have been subjected to the practise in places including Africa, the Middle-East, and Asia[25].

The Dawoodi Bohra Muslim Community, which migrated to India in the 1500s, is the primary group that engages in female genital mutilation. Since then, the practise has become more prevalent under the guise of "*essential religious practise*", along with a defence for restricting women's sexual inclinations. The Supreme Court in

[23] Meera Santosh Pal & Ors. v.Union of India & Ors., (2017) 3 SCC 462.
[24] X v. The Principal Secretary, Health and Family Welfare Department, Govt. of NCT of Delhi, Special Leave Petition (Civil) No 12612 of 2022. [hereinafter *X v. NCT of Delhi*]
[25] Female genital mutilation | National Health Portal Of India, https://www.nhp.gov.in/disease/female-genital-mutilation (last visited Feb. 22, 2023).

K.S.Puttaswamy v. Union of India[26] emphasised that the right to privacy is essential to both life and personal liberty under Article 21[27]. When a child, who is unable to perceive the negative implications of FGM, is coerced to undergo the procedure, her sexual and reproductive rights are vitiated. In 2017, **Sunita Tiwari v. Union of India**[28], an advocate and social activist, filed a public interest litigation under Article 32[29] to ban the practice of female genital cutting or circumcision. Due to a lack of official documentation or research claiming the presence of such terrible practises, the petition still remains unanswered.

The severe physical and psychological repercussions of female genital mutilation make it urgently necessary to raise awareness about it. By interfering with their physical autonomy and putting them through needless pain and suffering, FGM breaches the fundamental human rights of girls and women. Significant bleeding, infections, urinary issues, and even death are all possible acute risks. Long-term effects include chronic pain, labour difficulties, sexual dysfunction, psychological trauma, and a variety of physical and mental health problems. FGM also reinforces negative gender stereotypes and disparities. It is frequently associated with entrenched ideals of innocence, modesty, and restraint in feminine sexuality. This practice leads to the subjugation of women and girls and fosters negative stereotypes. It interferes with their ability to control their own bodies and feeds destructive cycles of gender-based violence.

Although the practice is against both human and reproductive rights, India's precise municipal laws outlawing it are yet unknown.

- ***Access to Contraceptives***

According to the National Family Health Survey ("NFHS") (2015–16)[30], out of 53.5% of married women (aged 15–49) who used contraceptives, 47.8% resorted to modern methods of contraception. The focal point of Indian family planning norms was to

[26] K.S.Puttaswamy v. Union of India, (2019) 1 SCC 1. [hereinafter *Puttaswamy*]
[27] INDIA CONST., supra note 7.
[28] Sunita Tiwari v. Union of India, WP(C) No.286/17. [hereinafter *Sunita Tiwari*]
[29] INDIA CONST. art. 32.
[30] National Family Health Survey (NFHS-4), Government of India (2015-16), http://rchiips.org/NFHS/pdf/NFHS4/India.pdf (last visited Feb. 22, 2023).

limit population growth by regulating women's fertility, which disregarded women's reproductive and sexual rights. Owing to this flawed strategy, the failure of past NFHS was evident as the usage of contraception was lowest in ST women (48%), followed by OBC women (54%), and SC women (55%).[31]

The right to free access to contraceptives was first recognized in **Suchita Srivastava**[32], then strengthened in **Puttaswamy**[33], which linked it to Article 21[34] under the purview of life and personal liberty. In the case of **Devika Biswas v. Union of India**[35], the Apex Court expanded the scope of a woman's reproductive rights to include the right to access a variety of reproductive health information, that would facilitate a person in making an informed choice about their reproductive behaviour. Contraceptives must be readily available for women to safeguard their reproductive health. It aids in preventing unwanted pregnancy, which carries a number of health hazards such as maternal mortality, unsafe abortions, and challenging labour and delivery. By encouraging safer sexual activities, contraceptives also help lower the prevalence of sexually transmitted diseases (STIs). Women who have access to contraceptives have more control over their periods, their cycles, and the symptoms of their periods, such as discomfort and excessive bleeding.

VII. ABORTION IN INDIAN CONTEXT

In September 2022 i.e. after five-decades of the Act of 1971, a three-judge bench of the Supreme Court, comprising Justices D.Y. Chandrachud, A.S. Bopanna, and J.B. Pardiwala in **X v. NCT of Delhi**[36] allowed a special leave petition of an unmarried woman to have a safe and legal abortion of up to 24 weeks of pregnancy and declared that an unmarried woman has an equivalent right to abortion as a married woman. The historic verdict has been termed "progressive" and interprets the term "women" to include trans women who may exercise the right. Nonetheless, it can be stated that the right to abortion has witnessed a huge transition from the 1960s, i.e., the era in

[31] Id. at 29.
[32] Suchita Srivastava, supra note 22.
[33] K.S.Puttaswamy, supra note 26.
[34] INDIA CONST., supra note 7.
[35] Devika Biswas v. Union of India, W.P.(C) 81/2012.
[36] X, supra note 24.

which the act of causing miscarriage was criminalised under a product of colonial rule, i.e., the IPC (Sections 312-316)[37]. Encountering high maternal mortality and morbidity rates[38] that were consequential to the rigid abortion laws, the Government of India drafted a committee chaired by Dr. Shantilal Shah[39] (a medical professional) to propose certain draft laws on abortion. In 1964, the committee drafted a report supporting legalisation of abortion on both compassionate and medical grounds, relying upon which the medical termination bill was passed and subsequently enacted as the Medical Termination of Pregnancy Act, 1971.

- **Development in Abortion Laws**

The Act of 1971 legalised abortion of up to twenty weeks on the grounds of rape, failure of contraceptives, and substantial risk to the foetus and the woman carrying it. It was the first legislation that formally recognised and regulated abortion as a legal right. However, sooner it was realised that the scope of the Act of 1971 is constricted in three aspects—(a) the Act was discriminatory towards unmarried women by being silent on non-marital pregnancies and disregarded the fact that the foetus survives on the woman's body irrespective of her status; (b) access to abortion was limited to state-run hospitals, leaving private hospitals unregulated; and (c) the limit of 12 weeks was very low.

In addition, practical challenges such as logistical impediments to offering abortion services compelled women to turn to risky practices. It is pertinent to note that, as per the NFHS (2015-16)[40], 47% of abortions performed were through unsafe methods, i.e., by a domestic partner, family member, or self, and the rest, 53%, were performed by registered medical practitioners ("**RMPs**"). The All India—Rural Statistics of 2018–19

[37] Indian Penal Code, 1860, § 312 - 316, No. 45, Acts of Parliament, 1860 (India).
[38] World Health Organisation 'Health Statistics and Information Systems, www.who.int/healthinfo/statistics/indmaternalmortality/en/ (last visited Feb. 22, 2023).
[39] Medical Abortion in India, https://aiims.edu/aiims/events/Gynaewebsite/ma_finalsite/report/1_1_4.htm (last visited Feb.,28 2023)
[40] Medical Termination of Pregnancy (Amendment) Bill, 2020, https://prsindia.org/billtrack/the-medical-termination-of-pregnancy-amendment-bill-2020 (last visited Feb.,28 2023)

depicted that rural areas fell short of 75% qualified doctors[41]; this clearly explains why rural women were not unable to access the designated abortion services.

The Judiciary's Deflecting Interpretations of the Act of 1971, led to inconsistency and a set of confusing judgements. In **Dr. Nikhil D. Datar v. Union of India**[42], the SC denied the inclusion of *eventualities* in Section 3[43] and rejected the petition to grant abortion to a foetus diagnosed with complete heart block at the 26th week of pregnancy. However, in the similar case of **X v. Union of India**[44], the pregnancy beyond 20 weeks was allowed under Section 5 of the Act, citing that its continuation would pose a grave threat to the woman's physical and mental health. The Act of 1971 was revised in 2002[45]; however, the prevalent anomalies remained unnoticed until the 2021 Amendment..

- ***Medical Termination of Pregnancy (Amendment) Act, 2021***

In 2020, the Medical Termination of Pregnancy (Amendment) Bill[46] ("MTPA Bill") was introduced and became an amendment in March 2021. The Amendment Act of 2021 brought significant changes such as—(a) the gestational limit was extended to 24 weeks in case of the opinion of two RMPs and up to 20 weeks in case of the opinion of one RMP (Section 3(2))[47]; (b) it extended its application beyond married women including every person other than cis-gender and irrespective of their marital status (Section 6)[48]; (c) the constitution of Medical Boards was directed in all the states and Union Territories for diagnosing substantial foetal abnormalities' (Section 3(2B))[49]; (d)

[41] Medical Abortion in India, supra note 37.
[42] Dr. Nikhil D. Datar v. Union of India, SLP (C) 5334 of 2009.
[43] Medical Termination of Pregnancy Act, 1971, § 3, No. 34, Acts of Parliament, 1971 (India).
[44] X v. Union of India & Ors., 25 July 2016 (WP(C)593/2016).
[45] Medical Termination of Pregnancy (Amendment) Act, 2002.
[46] Medical Termination of Pregnancy (Amendment) Bill, supra note 38.
[47] Medical Termination of Pregnancy (Amendment) Act, 2021, § 3(2), No. 8, Acts of Parliament, 2021 (India).
[48] Medical Termination of Pregnancy (Amendment) Act, 2021, § 6, No. 8, Acts of Parliament, 2021 (India).
[49] Medical Termination of Pregnancy (Amendment) Act, 2021, § 3(2B), No. 8, Acts of Parliament, 2021 (India).

it supports the right to privacy of the woman by ensuring that RMP would not reveal the details of the woman except authorised by law (Section 4)[50].

- **Potential Barriers in Effective Implementation of the Act & Suggestions**

On paper, the Amendment Act of 2021 appeared utopian, but it still left some problems open, leaving women vulnerable to implementation difficulties.

  - **Flawed Intent of the Legislature:**

The Principal legislation when read with the 2021 Amendment Act unfolds three situations of abortions. *Firstly*, if the term of pregnancy is of twelve weeks, the termination was dependent upon the opinion of one registered medical practitioner. *Secondly*, if the term of pregnancy ranges between twelve to twenty four weeks, then pregnancy can be terminated in the opinion of two registered medical practitioners. In either of the situations, the pregnancy has to be terminated on *bona fide grounds* i.e. if the continuation of pregnancy poses a risk to the life of the pregnant woman or child[51]. *Thirdly,* if the pregnancy term exceeds twenty-four weeks, then termination will be decided by a Medical Board constituted by respective State or Union Territory.

These regulations have made terminating a pregnancy substantially simpler, yet a detailed reading of the rules reveals that access to abortion is strictly governed by the law. The woman who wants an abortion must make sure that her request is legitimate within the law, which is nothing more than state-approved restrictions on her right. Despite laws that contradict women's rights to privacy, reproductive autonomy, and bodily autonomy, it is important to note the Indian judiciary's attempt in **Suchita Srivastava[52]**, where the Court determined that a woman's right to make reproductive decisions is also a dimension of "personal liberty" as understood by Article 21.

Tracing the judicial precedent set by the **Suchita Srivastava[53]**, the Madhya Pradesh High Court in **Halo Bi v. State of Madhya Pradesh[54]**, upheld the aspect of

[50] Medical Termination of Pregnancy (Amendment) Act, 2021, § 4, No. 8, Acts of Parliament, 2021 (India).
[51] Medical Termination of Pregnancy (Amendment) Act, 2021, supra note 45.
[52] Suchita Srivastava, supra note 22.
[53] Id. at 50.
[54] Halo Bi v. State of Madhya Pradesh & Ors., WP(C) 7032/2012.

autonomous decision to abort as an aspect of personal liberty enshrined under Article 21[55], and explicitly mentioned, "*we cannot force a victim of violent rape/forced sex to give birth to a child of a rapist. The anguish and the humiliation which the petitioner is suffering daily,* ***will certainly cause a grave injury to her mental health.***" Unfortunately, the existence of such landmark decisions has not resulted in a dramatic shift in power towards women; rather, it regulates medically assisted abortion, enacts state-approved conditions, and restricts women's rights.

Suggestion - Initiate extensive awareness and education initiatives to acquaint women and healthcare professionals about the amendment act's provisions. The subject matter of these campaigns ought to be women's reproductive rights, the legal system, and the procedure for obtaining safe and legal abortions. It will be easier to implement and decision-making will be more informed with the help of education for both women and medical professionals.

- **Inconsistent Local Laws:**

The POCSO 2012[56] and the PCPNDT 1994[57], have been barriers in the implementation of the Act of 1971 and subsequently the 2021 Amendment Act. To safeguard children from sexual abuse, the POCSO Act was passed. The POCSO necessitates reporting cases of minor pregnancies, which is in direct conflict with the terms of the 2021 Amendment Act because it places restrictions on the dissemination of specifics on respective females and upholds their right to secrecy and privacy.

The PCPNDT Act, which seeks to forbid female feticide and subsequent foetal sex selection, acts as a barrier in situations where abortion is desired for reasons other than the intended gender. For fear of being prosecuted with a crime under the Act, medical professionals abstain from providing services.

Suggestion - In order to ensure that reporting obligations do not restrict a woman's access to abortion or jeopardise her privacy, it is necessary to harmonise contradictory laws like the POCSO Act and the PCPNDT Act with the 2021 Amendment Act.

[55] INDIA CONST., supra note 7.
[56] Prevention of Children from Sexual Offences Act, 2012 (India).
[57] Pre-Conception Pre-Natal Diagnostic Techniques Act, 1994 (India).

- **Operative Barriers:**

The Act grants "registered medical practitioners" the authority to perform abortions. Furthermore, according to the NCBI's report from 2020[58], just 40% of the medical professionals who were surveyed had received MTP training. The accessibility of abortion is hampered by these special RMP requirements. Moreover, the methods of availing abortion either vaginally or orally should be pocket-friendly and at affordable prices. Further, budget allocation for abortion related aspects should be increased.

Suggestion - Should increase the pool of RMPs by organising training camps on safe abortion procedures and reproductive healthcare. Include AYUSH and lower medical staff to provide abortion-related services.

VIII. FEMALE GENITAL MUTILATION

Female Genital Mutilation ("FGM"), also known as Female Genital Cutting ("FGC"), is a procedure that involves the "*partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons,*" as stated by the World Health Organisation[59]. According to the various regions where the practice is carried out, FGM is known by different names such as Sunna, Halalays, Megrez, etc. WHO has officially classified FGM into four types:

- *Type I:* Clitoridectomy - Partial or total removal of the clitoris.
- *Type II:* Excision - Partial or total removal of the clitoris and labia minora with or without the removal of the labia majora.
- *Type III:* Infibulation - Stitching the vagina by cutting and repositioning the labia, leaving a small opening for urination.
- *Type IV:* Any other harmful procedure to the female genitalia for non-medical purposes, including piercing, pricking, incising, scraping, and cauterizing the genital area.

[58] Women's health reports (New Rochelle, N.Y.), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7784791/ (last visited Mar.2, 2023).
[59] What is female genital mutilation?, UNICEF, https://www.unicef.org/stories/what-you-need-know-about-female-genital-mutilation (last visited Mar. 03, 2023)

FGM has detrimental repercussions on the physical, psychological, and social well-being of women and girls. Acute effects can include debilitating pain, bleeding, infections, urinary problems, and even death. Long-term repercussions may include persistent pain, complications during childbirth, an increased risk of infection, sexual dysfunction, psychological trauma, and social embarrassment. The practice undermines women's physical integrity, sexual autonomy, and overall well-being while perpetuating discrimination and gender disparity, it constitutes a violation of human rights.

IX. ORIGIN OF THE PRACTICE

The exact origin of FGM remains known because there are no conclusive facts about the emergence of FGM. One of the theories suggest that FGC originated in Egypt as circumcised and infibulated mummies were discovered in the 5th century BC[60]. FGC was important in Egypt as it marked the criteria for women's marriage, inheritance of property, and acceptance in the society of Egypt. The practice extended to the western shore of the Red Sea among the tribes through Arabian traders. According to Hanry Lightfoot- Klein[61], an author, FGM was done to control the population as it curbed the sexual desire of women and made them sexually modest women. After the Egyptians, FGC was also noticed in the Islamic religion[62]. In the 13th century, this practice was introduced in South East Asian countries. It was also observed in European countries[63]. Around the 1860s[64], Issar Baker Brown made an observation that masturbation leads to hysteria, which can ultimately lead to death. He suggested that females tend to masturbate frequently because of the presence of the clitoris, which increases sexual desire in a woman's body. According to Brown, the only way to cure this problem was clitoridectomy.

[60] Tracing the Origins of Female Genital Cutting: How It All started, SAHIYO, https://sahiyo.com/2018/07/21/tracing-the-origins-of-female-genital-cutting-how-it-all-started/ (last visited Mar. 3, 2023)
[61] Id at 58.
[62] Tracing the Origins of Female Genital Cutting: How It All started, SAHIYO, supra note 58.
[63] Female Circumcision: The History, the Current Prevalence and the Approach to a Patient, https://med.virginia.edu/family-medicine/wp-content/uploads/sites/285/2017/01/Llamas-Paper.pdf (last visited Mar. 3, 2023)
[64] NHS Choices, https://www.nhs.uk/conditions/female-genital-mutilation-fgm/ (last visited Mar. 3, 2023)

According to Dr. Howard Kelly of John Hopkins University[65], the adhesions between the clitoris and hood lead to irritation which subsequently led to masturbation. At that time, masturbation was considered a disease, and cutting of the clitoral hood was considered a reliable treatment for it. After all these statements in the late 1960s, Sarah Rodriguez[66] observed that FGM was practiced in Western Countries to control female sexuality, which discriminates against gender-based rights by restricting women from making any choices related to their sexuality.

X. THE WIDESPREAD CUSTOM

Internationally, the practice is prevalent in 92 countries[67] worldwide including Iraq, Yemen, Indonesia, Somalia, Guinea, Djibouti, Cameroon, Uganda, Colombia, India, Malaysia, Oman, Saudi Arabia, the United Arab Emirates, some parts of Europe, Australia, North America, etc. Certain Islamic groups, Christians, Ethiopian Jews, and followers of traditional African religions are advocates of FGC. Generally, three main reasons are cited for the observance of this abuse. *Firstly*, it is believed that it is done to maintain and control the virginity, purity, and sexual desires of a woman. *Secondly,* because the practice has been followed for years by mothers and their daughters, it is perceived by the coming generation that their community will not accept them if they don't follow their religious beliefs. *Thirdly* in several cultures, the process of FGM is linked with hygiene and pregnancy among women. It is believed that the process improves the health of a young woman and increases a woman's probability of conception during sexual intercourse.

In the Indian Scenario, FGM is practiced as a custom among the members of the Dawoodi Bohra Community[68] (**"Bohra Community"**)**,** where the practice is termed as "*Khatna*" or "*Khazf*". They consider themselves the direct descendants of Prophet Mohammed. The practice primarily began in Egypt and Yemen, and was introduced

[65] Id. at 62.
[66] Tracing the Origins of Female Genital Cutting: How It All started, SAHIYO, supra note 58.
[67] Female genital mutilation (FGM) frequently asked questions, United Nations Population Fund, https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions#where_practiced (last visited Mar. 3, 2023).
[68] About the Dawoodi Bohras, The Dawoodi Bohras, https://www.thedawoodibohras.com/about-the-bohras/ (last visited Mar. 03, 2023)

to India in the 1500s upon migration. Currently, the Bohra Community is found in Gujarat, Rajasthan, Maharashtra, and Madhya Pradesh[69]. The community believes that Khatna is one of the "*essential religious practices*'' that every Muslim Bohra girl must follow. According to their belief, the clitoris in a female's body is considered impure, or in their language, "*haram ki boti,*" and must be removed to maintain purity and virginity. This practice aims to ensure that women do not engage in any pre-marital relationships.[70]

FGM is ingrained in certain communities' cultural beliefs and customs, where it is falsely associated with ideas of chastity, modesty, and social acceptance. Although some individuals mistakenly link FGM to religious practice, it is crucial to remember that no major religion supports or mandates FGM. In reality, the practice is deemed to be a violation of human rights by many religious authorities and organizations. FGC has immediate and long-lasting impacts on women, with serious physical, psychological, and social repercussions. Women may endure severe pain, bleeding, infection, and difficulty urinating or menstruating immediately after the procedure. Long-term consequences can include chronic discomfort, urinary and reproductive issues, an elevated risk of infections, complications during childbirth, and even death. Furthermore, as FGM is intended to control women's sexuality and reinforce social norms regarding their bodies, it often perpetuates harmful gender norms and contributes to gender inequality. To end FGC and promote the rights of women and girls, it is essential to raise awareness, advocate for legislation, and provide education.

XI. HOW IS THE PROCESS OF FGM CARRIED OUT?

The process of carrying out FGM varies in severity and technique, but it generally involves the partial or total removal of external female genitalia. This horrific procedure is often conducted under unhygienic conditions, without anesthesia, and by traditional practitioners who lack medical training. Tools such as knives, scissors, or razor blades are used to excise the clitoris, labia, and sometimes even to partially

[69] Why do Dawoodi Bohras practice Khatna, or Female Genital Cutting?, https://sahiyo.com/2017/05/19/why-do-dawoodi-bohras-practice-khatna-or-female-genital-cutting/ (last visited Mar. 3, 2023).
[70] About the Dawoodi Bohras, The Dawoodi Bohras, supra note 66.

sew the vaginal opening shut, leaving only a small hole for urine and menstrual blood to pass through. The process is implemented in two ways–either by an old woman, also called a "midwife," or by a traditional women's circumciser ("Mullani") using knives, scissors, scalpels, pieces of glass, or razor blades without using anesthesia or antibiotics, or through medicalization, where the procedure is carried out by a healthcare provider.When an elder woman in the family carries out the process, there is a possibility that she might use the same knife on up to 30 girls without sterilizing or cleaning it, exposing the subjected female to genital infections. As the after-effects of the procedure are severe and can lead to the death of the girl if precautionary measures are not taken, in some countries, FGM is carried out by health care providers. *Therefore, nowadays, medicalization is preferred over midwives.*

- ***Targeted Age Group:***

Different communities consider different age ranges as suitable time for FGM. While some consider the best age to carry out FGM is when girls are between the ages of 6 and 12 years old, as they are less resistant and it becomes easier for the cutter to remove the clitoris, others believe the age between 7 and 14 years old is best. In a few communities, women are cut just before marriage because this process is believed to prove that the girl is a virgin and is eligible to marry. Some families carry out this procedure right after the start of menarche because, according to them, it helps women control their sexual desires and restricts them from having any physical relationships before marriage.[71]

XII. SCATTERED INDIAN LAWS

The physical and psychological consequences of FGM are severe and lifelong, ranging from excruciating pain to infections, infertility, complications during childbirth, and profound psychological trauma, along with the possibility of death. However, observers of this practice, especially the Dawoodi Bohra Community, have argued that their right to practise FGM is protected under Articles 25 and 26[72] of the

[71] Welcome to the United Nations, https://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf (last visited Mar. 3, 2023).
[72] INDIA CONST. art. 25 & 26.

Constitution of India as an "*essential religious practice*". But the fact is that FGM directly violates the right to reproductive autonomy, as observed in **Suchita Srivastava**[73] and **Puttaswamy**[74], which forms an integral part of Article 21[75]. The practise is violative of the principles of gender equality as it is limited to females during their formative years, i.e., they are unable to comprehend the intricacies involved and the after-effects of such a process; therefore, the concept of informed consent is diluted. Additionally, it is against public order, health, and morality.

The laws under which the said practise can be criminalized are—*Firstly*, sections 319 to 326[76] of the IPC that deal with hurt and grievous hurt in various forms. FGM can be construed as a form of grievous hurt and can be penalised under Sections 324[77] and 326[78] of the IPC, as it renders the body incapable of normal activities like urinating and makes sexual intercourse painful rather than pleasurable. *Secondly*, it can be criminalized under the offense of penetrative sexual assault[79] under the POCSO Act 2012. An attempt was made to ban the practise through the filing of a Public Interest Litigation in the Supreme Court by Advocate **Sunita Tiwari**[80] in 2017. In response, the Ministry of Women and Child Development stated that there is no official data[81] or study supporting the existence of FGM in India. Therefore, no action can be taken against the practice until official data is reported. The petition was further referred to a constitutional bench and is still pending.

[73] Suchita Srivastava, supra note 22.
[74] K.S.Puttaswamy, supra note 26.
[75] INDIA CONST., supra note 7.
[76] Indian Penal Code, 1860, § 319 - 326, No. 45, Acts of Parliament, 1860 (India).
[77] Indian Penal Code, 1860, § 324, No. 45, Acts of Parliament, 1860 (India).
[78] Indian Penal Code, 1860, § 326, No. 45, Acts of Parliament, 1860 (India).
[79] Prevention of Children from Sexual Offences Act, 2012, § 3 & 4, No. 32, Acts of Parliament, 2012 (India).
[80] Sunita Tiwari, supra note 27.
[81] No evidence of FGM, India government tells court, appalling activists, https://www.reuters.com/article/us-india-women-religion-idUSKBN1EN0QB/ ((last visited Mar. 3, 2023).

XIII. POTENTIAL BARRIERS IN CRIMINALISATION OF THE EVIL PRACTICE

Thirty nations have passed national laws against FGM since the UNICEF and UNFPA[82] Joint Programme in 2008. Female genital cutting was outlawed by the UN in 2012 through a resolution, and February 6th was even declared an International Day of Zero Tolerance for Female Genital Mutilation. Despite the significant international covenants against FGM, the practice still remains unnoticed and prevails in India due to various underlying reasons.

- **Guise of Religious Practice:**

"*Amongst Islamic scholars, there is a dichotomous difference of opinion on the matter, with some claiming the practice is obligatory and others claiming it is acceptable, but not mandatory. Other Islamic scholars claim that the practice has no basis in Islam; there is no mention of a direct call for practicing FGC in the Quran. However, amongst Dawoodi Bohras, FGC is often considered to be an unspoken tradition mandated by the religious clergy.*"[83] Communities practising FGM contend it is an "*essential religious practise*". Due to this belief, even those who are unwilling may feel compelled to follow it to avoid punishment from God or to avoid societal ostracization.

- **Lack of Official Data:**

In 2017, Sahiyo, a NGO, released a report[84] on FGM in India that depicted that most members of the Dawoodi Bohra community resided in India, and almost 49% of subjects knew someone who had been through khatna. As a result of this report, the Ministry of Women and Children Development asked the Dawoodi Bohra community to end the practice. However, later on, the data was termed "unofficial," leaving the offenders free.

- **Health, Hygiene & Sexual Control:**

[82] United Nations Population Fund, 1969.
[83] LSE Human Rights, https://blogs.lse.ac.uk/humanrights/2022/05/06/female-genital-mutilation-cutting-in-india-an-urgent-need-for-intervention/ (last visited Mar. 5, 2023).
[84] Understanding Female Genital Cutting in the Dawoodi Bohra Community, https://archive.org/details/sahiyo_report_fgc (last visited Mar. 5, 2023).

Supporters of FGM claim that it enhances sexual relationships and has positive health benefits. Some tribes believe that since female genitalia are considered dirty, they should be chopped off. FGM is often thought to ensure a woman's virginity and purity. While most of these views are held by women, none of them have any academic or medical support. It is possible that these beliefs are a result of patriarchal traditions that force women into subordinate gender-roles.[85]

XIV. WHAT CAN BE DONE?

FGM is a covert societal evil deeply ingrained in social networks. Therefore, the only way to end FGM is to raise awareness of its health effects. In addition, emergency medical facilities should be provided to treat FGM victims, who should be treated with the highest respect, and their anonymity should be maintained. It should be ensured that they file complaints. Proponents of such practices should also face legal action under the Indian Penal Code, 1860 and the POCSO Act of 2012 until the Indian government passes a law outlawing these practices.

XV. INTERSECTIONALITY OF ABORTION AND FGM

The term "intersectionality" describes how social categories like race, class, gender, and sexual orientation are interrelated and result in overlapping systems of discrimination and disadvantage. Even though the abortion and FGM are separate, they are linked by how they affect women's reproductive and bodily autonomy. The attitudes and social conventions that surround both practices are greatly influenced by society. The oppression of women is sustained by patriarchal institutions, which are based on male dominance and control and manifest in limitations on female reproductive freedom and harmful cultural customs.

The struggle for women's agency over their own bodies is highlighted by the frequent heated debate surrounding abortion. Social norms and judicial systems may facilitate or restrict women's access to safe and legal abortion services. Patriarchal norms that place a premium on male judgement and aim to control women's reproductive lives can result in restrictive abortion legislation and the stigmatisation of pregnant women.

[85] LSE Human Rights, supra note 81.

The damaging practise of female genital mutilation is also widespread in patriarchal environments. It illustrates how society standards and expectations continue to control and oppress women's bodies. FGM frequently has roots in ideas of chastity, purity, and control of female libido. Women and girls are exposed to bodily and psychological harm as a result of these practises, which are supported by patriarchal structures that give priority to male authority and domination. Both behaviours unfairly disadvantage marginalised groups, aggravating the injustices endured by people who encounter many forms of discrimination based on their colour, social standing, or immigrant status.

XVI. CONCLUSION

In recent years, India's legal landscape has witnessed significant changes in the realm of reproductive rights, particularly regarding abortion laws and the practice of Female Genital Mutilation. The evolution of the Medical Termination of Pregnancy Act from its inception in 1971 to the latest amendments in 2021 reflects a growing recognition of women's rights, including those of unmarried women, to access safe and legal abortion services. However, challenges persist in effectively translating these legal provisions into accessible healthcare services, especially in rural areas where facilities are limited. Additionally, conflicts with other laws, such as the POCSO Act and the PCPNDT Act, pose obstacles to the comprehensive implementation of abortion laws.

Concurrently, the practice of FGM remains a pressing concern, particularly within the Dawoodi Bohra community, where it is considered a religious practice. Efforts to criminalize FGM under existing laws, such as the Indian Penal Code and the POCSO Act, face challenges due to the perceived religious significance of the practice and the lack of official data on its prevalence. FGM violates women's rights to bodily integrity and autonomy, perpetuating harmful gender stereotypes and inequality. While progress has been made in recognizing and protecting reproductive rights in India, there are persistent challenges in effectively implementing these laws and addressing cultural practices like FGM. Addressing these challenges requires a multifaceted approach. Comprehensive awareness programs are needed to educate women and

healthcare providers about reproductive rights and the legal framework governing abortion and FGM.

Harmonizing conflicting laws and providing extensive training for medical practitioners are essential steps in ensuring equitable access to reproductive healthcare services. A comprehensive strategy that combines legal reforms, education, and healthcare initiatives is essential to ensure the full realization of women's reproductive rights and the eradication of harmful practices that undermine their well-being and autonomy.